Texas Department of Insurance
Division of Workers' Compensation
Medical Fee Dispute Resolution, MS-48
7551 Metro Center Drive, Suite 100 • Austin, Texas 78744-1645
512-804-4000 telephone • 512-804-4811 fax • www.tdi.texas.gov

MEDICAL FEE DISPUTE RESOLUTION FINDINGS AND DECISION

GENERAL INFORMATION

Requestor Name
REJESH G. ARAKAL, MD

Respondent Name
TEXAS MUTUAL INSURANCE CO

MFDR Tracking Number
M4-14-3108-01

Carrier's Austin Representative
Box Number 54

MFDR Date Received
JUNE 11, 2014

REQUESTOR'S POSITION SUMMARY

Requestor's Position Summary: "This was an Emergency Surgery & w/c urles states you "DO NOT" need authorization for Emergency Surgery. Please review Operative Report."

Amount in Dispute: $7,677.00

RESPONDENT'S POSITION SUMMARY

Respondent's Position Summary: "Texas Mutual maintains its position the surgery required preauthorization."

Response Submitted by: Texas Mutual Insurance Co.

SUMMARY OF FINDINGS

Dates of Service	Disputed Services	Amount In Dispute	Amount Due
February 13, 2014	CPT Code 63710-59 Dural graft, spinal	$3,737.00	$2,086.81
	CPT Code 63030 Lumbar Spinal Surgery	$3,283.00	$916.81
	CPT Code 63035 Lumbar Spinal Surgery	$657.00	$367.12
TOTAL		$7,677.00	$3,370.74

FINDINGS AND DECISION

This medical fee dispute is decided pursuant to Texas Labor Code §413.031 and all applicable, adopted rules of the Texas Department of Insurance, Division of Workers' Compensation.

Background

1. 28 Texas Administrative Code §133.307 sets out the procedures for resolving a medical fee dispute.
2. 28 Texas Administrative Code §134.203, titled *Medical Fee Guideline for Professional Services*, effective March 1, 2008, sets the reimbursement guidelines for the disputed service.
3. 28 Texas Administrative Code §133.2, effective July 27, 2008, 33 TexReg 5701, defines a medical emergency.
4. 28 Texas Administrative Code §134.600, requires preauthorization for specific treatments and services.

5. The services in dispute were reduced/denied by the respondent with the following reason codes:
   - CAC-197-Precertification/Authorization/Notification absent.
   - 930-Pre-authorization required, reimbursement denied.

Issues

1. Does the submitted documentation support a medical emergency?
2. Is the requestor entitled to reimbursement?

Findings

1. The insurance carrier denied reimbursement for the disputed spinal surgery, based upon "CAC-197-Precertification/Authorization/Notification absent," and "930-Pre-authorization required, reimbursement denied."

   The requestor states in the position summary that "This was an Emergency Surgery & w/c urles states you "DO NOT" need authorization for Emergency Surgery. Please review Operative Report."

   28 Texas Administrative Code §134.600 (c)(1)(A), states "The carrier is liable for all reasonable and necessary medical costs relating to the health care: (1) listed in subsection (p) or (q) of this section only when the following situations occur: (A) an emergency, as defined in Chapter 133 of this title (relating to General Medical Provisions);

   28 Texas Administrative Code §133.2 (3) defines "Emergency--Either a medical or mental health emergency as follows: (A) a medical emergency is the sudden onset of a medical condition manifested by acute symptoms of sufficient severity, including severe pain, that the absence of immediate medical attention could reasonably be expected to result in: (i) placing the patient's health or bodily functions in serious jeopardy, or (ii) serious dysfunction of any body organ or part."

   A review of the operative report states "She was being followed conservatively. She had progressive acute change in worsening of neurologic deficit and weakness in the tibialis anterior and EHL…Because of inability to ambulate, she was brought urgently to Medical Center of Plano where upon which she was admitted and repeat imaging confirmed disk herniations at L4-5 and L5-S1 that were large. The patient had gone on to progressive weakness which required urgent attention."

   The respondent did not submit any documentation to dispute requestor's assertion that claimant's condition was a medical emergency; therefore, per 28 Texas Administrative Code §134.600 (c)(1)(A), preauthorization was not required.

2. On the disputed date of service the requestor billed CPT codes 63710-59, 63030, and 63035.
   - CPT code 63710 is defined as "Dural graft, spinal."
   - CPT code 63030 is defined as "Laminotomy (hemilaminectomy), with decompression of nerve root(s), including partial facetectomy, foraminotomy and/or excision of herniated intervertebral disc; 1 interspace, lumbar."
   - CPT code 63035 is defined as "Laminotomy (hemilaminectomy), with decompression of nerve root(s), including partial facetectomy, foraminotomy and/or excision of herniated intervertebral disc; each additional interspace, cervical or lumbar (List separately in addition to code for primary procedure)."

   Per 28 Texas Administrative Code §134.203(c)(1)(2), "To determine the MAR for professional services, system participants shall apply the Medicare payment policies with minimal modifications.
   (1) For service categories of Evaluation & Management, General Medicine, Physical Medicine and Rehabilitation, Radiology, Pathology, Anesthesia, and Surgery when performed in an office setting, the established conversion factor to be applied is $52.83. For Surgery when performed in a facility setting, the established conversion factor to be applied is $66.32.
   (2) The conversion factors listed in paragraph (1) of this subsection shall be the conversion factors for calendar year 2008. Subsequent year's conversion factors shall be determined by applying the annual percentage adjustment of the Medicare Economic Index (MEI) to the previous year's conversion factors, and shall be effective January 1st of the new calendar year. The following hypothetical example illustrates this annual adjustment activity if the Division had been using this MEI annual percentage adjustment: The 2006 Division conversion factor of $50.83 (with the exception of surgery) would have been multiplied by the 2007 MEI annual percentage increase of 2.1 percent, resulting in the $51.90 (with the exception of surgery) Division conversion factor in 2007."

To determine the MAR the following formula is used: (DWC Conversion Factor/Medicare Conversion Factor) X Participating Amount = Maximum Allowable Reimbursement (MAR).

The 2014 DWC conversion factor for this service 69.98.

The Medicare Conversion Factor is 35.8228.

Review of Box 32 on the CMS-1500 the services were rendered in zip code 75075, which is located in Plano, Texas. Therefore, the Medicare participating amount will be based on the reimbursement for "Rest of Texas".

Using the above formula, the Division finds the following:

CODE	Medicare Participating Amount	Maximum Allowable Reimbursement	Carrier Paid	Total Due
63710	$1,068.24	$2,086.81	$0.00	$2,086.81
63030	$938.63	$916.81	$0.00	$916.81
63035	$187.93	$367.12	$0.00	$367.12

Conclusion

For the reasons stated above, the Division finds that the requestor has established that reimbursement is due. As a result, the amount ordered is $3,370.74.

ORDER

Based upon the documentation submitted by the parties and in accordance with the provisions of Texas Labor Code Sections 413.031 and 413.019 (if applicable), the Division has determined that the requestor is entitled to additional reimbursement for the services involved in this dispute. The Division hereby ORDERS the respondent to remit to the requestor the amount of $3,370.74 plus applicable accrued interest per 28 Texas Administrative Code §134.130, due within 30 days of receipt of this Order.

Authorized Signature

Signature	Medical Fee Dispute Resolution Officer	01/30/2015 Date

YOUR RIGHT TO APPEAL

Either party to this medical fee dispute has a right to seek review of this decision in accordance with 28 Texas Administrative Code §133.307, effective May 31, 2012, *37 Texas Register 3833*, **applicable to disputes filed on or after June 1, 2012**.

A party seeking review must submit a **Request to Schedule a Benefit Review Conference to Appeal a Medical Fee Dispute Decision** (form **DWC045M**) in accordance with the instructions on the form. The request must be received by the Division within **twenty** days of your receipt of this decision. The request may be faxed, mailed or personally delivered to the Division using the contact information listed on the form or to the field office handling the claim.

The party seeking review of the MDR decision shall deliver a copy of the request to all other parties involved in the dispute at the same time the request is filed with the Division. **Please include a copy of the *Medical Fee Dispute Resolution Findings and Decision*** together with any other required information specified in 28 Texas Administrative Code §141.1(d).

Si prefiere hablar con una persona en español acerca de ésta correspondencia, favor de llamar a 512-804-4812.